Macomb County Health Department

Starting School 2012

A Guide for Parents

MACOMB COUNTY HEALTH DEPARTMENT

Mount Clemens Health Center

43525 Elizabeth Road ♦ Mount Clemens, Michigan 48043

586-469-5235 FAX 586-469-5885

macombcountymi.gov/publichealth

Mark A. Hackel
County Executive

Steven C. Gold, M.P.H.
Director/Health Officer

Kevin P. Lokar, M.D.
Medical Director

Dear Parent:

Starting school is a big event in every child's life! School will be your child's "second home" for years to come. A child who is physically and emotionally ready for school will have the best chance for success. With these thoughts in mind, the Macomb County Health Department has prepared this booklet to inform you of the following:

- Required Immunizations
- Required vision and hearing screening
- Physical and dental examination form
- Additional recommendations and tips

The Health Appraisal form in this booklet should be taken with you at the time of your child's physical and dental examinations. Your doctor and dentist should complete the appropriate sections of the form. The Macomb County Health Department offers immunizations and vision/hearing screening services. Please check the booklet for clinic locations, times, and phone numbers.

We hope you will find this information helpful. If you have further questions, do not hesitate to call the Macomb County Health Department at (586) 469-5235.

Good luck to you and your child as you start this new and challenging adventure.

Sincerely,

Kevin P. Lokar, M.D., M.P.H.
Medical Director

jab

IMMUNIZATIONS ARE REQUIRED

The State of Michigan & the Macomb County Immunization Ordinance requires children to be adequately immunized to start school.

TO ENTER SCHOOL

Your child must have the following vaccines:

- 1dose of DTP/DTaP –
  Diphtheria, Tetanus, Pertussis (Whooping Cough)
- 1 dose of Polio
- 1 dose of MMR – Measles, Mumps & Rubella (must be received on or after the 1st birthday)
  OR Laboratory proof of immunity
- 1 dose of Hepatitis B
  OR Laboratory proof of immunity
- 1 dose of Varicella (chickenpox) (must be received on or after the 1st birthday)
  OR Laboratory proof of varicella immunity
  OR Provide a written statement from a parent/guardian or doctor verifying the child already had chickenpox disease

TO REMAIN IN SCHOOL

Children 4-6 Years of Age Must Have the Following Minimum Vaccines:

- 4 doses of DTP/DTaP with 1 dose on or after the 4th birthday
- 4 doses of Polio. If dose #3 was given on or after the 4th birthday, only 3 doses are needed.
- 2 doses of MMR and Varicella on or after the 1st birthday, at least 28 days apart from each other and/or the nasal flu vaccine
- 3 doses of Hepatitis B
- Appropriate spacing between all vaccines is essential for the development of adequate immunity. A complete date (month, day, year) for each vaccine is required. You will be contacted if there is a concern about the spacing of your child's vaccines.

SPECIAL NOTES

- **Always bring your child's immunization record to your doctor or Health Department clinic.**
- Get immunizations on time to avoid the last minute rush.
- Keep your child's immunization record in a safe place.
- If necessary, waiver forms are available at your school.

MACOMB COUNTY HEALTH DEPARTMENT
IMMUNIZATION CLINIC HOURS***

CENTRAL HEALTH CENTER 43525 Elizabeth Street Mount Clemens, MI 48043-1034 **(586) 469-5372** 8:30 a.m. to 5:00 p.m. Monday-Friday 8:30 a.m. to 6:30 p.m. Wednesday	*** Immunization clinic hours are subject to change. Please check the website or call for current hours. http://www.macombcountymi.gov/publichealth/
*** Immunization clinic hours are subject to change. Please check the website or call for current hours. http://www.macombcountymi.gov/publichealth/	**SOUTHEAST HEALTH CENTER** 25401 Harper Avenue Saint Clair Shores, MI 48081-2259 **(586) 466-6800** 8:30 a.m. to 5:00 p.m. Monday-Friday 8:30 a.m. to 6:30 p.m. Monday
SOUTHWEST HEALTH CENTER 27690 Van Dyke Avenue, Suite B Warren, MI 48093-2853 **(586) 465-8537** 8:30 a.m. to 5:00 p.m. Monday-Friday 8:30 a.m. to 6:30 p.m. Thursday	*** Immunization clinic hours are subject to change. Please check the website or call for current hours. http://www.macombcountymi.gov/publichealth/

Administration fees charged for each vaccine given. Fee list available. Clinic accepts cash or check only. Medicaid/Medicare covers fees for approved vaccines.

A parent or guardian must be available to sign clinic health forms for each child. Please bring your child's immunization record(s) and health insurance card(s). Bring an adult translator if unable to speak or read English.

Call (586) 469-5492 for MIChild-Healthy Kids, health insurance coverage for birth through age 18 and pregnant women.

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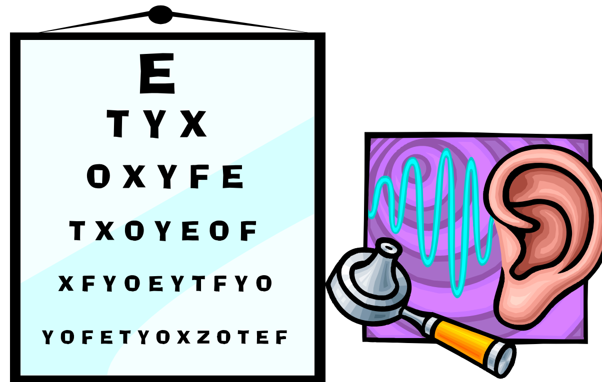
Administered by the Macomb County Health Department
http://www.macombcountymi.gov/publichealth

Hearing and Vision Program



- If your child has difficulties seeing or hearing, then your child may have difficulty learning.

- Difficulties can often be corrected if they are found at an early age, when they are easiest to treat.

Before Your Child Enters School

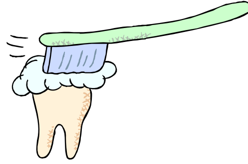
- Your child **must** have a Hearing and Vision Screening Test dated within one year of entering school.

The Macomb County Health Department offers this service **FREE** at many nursery schools, preschool programs, and **all** school districts. Appointments are available at various sites.

For more information, please call:
Macomb County Health Department
(586) 412-5945
Monday-Friday
8:30 a.m. - 5:00 p.m.

Authority: Act 368.1978

Dental Health Services For You and Your Family



Who is eligible for dental services?

- Must be a Macomb County resident
- Meet income guidelines and **do not** have dental insurance

OR

- Medicaid eligible persons

What kind of dental services will I receive?

- Low-cost, high quality service
- Qualified professional staff
- Modern, well-equipped facility
- Full range of dental services excluding braces, root canals, and pulling of teeth

How can I get more information?

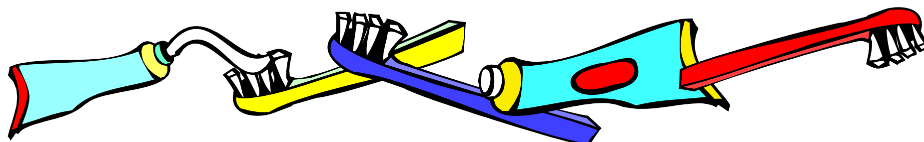
- Call the Dental Clinic at
  (586) 465-9152
  or to schedule an appointment

When is the Dental Clinic open?

Monday – Friday
8:30 a.m. – 5:00 p.m.

Where is the Dental Clinic?

27960 Van Dyke Avenue, Suite B
Warren, MI 48093-2853
(North of I-696, East side of Van Dyke Avenue)



TIPS FOR HEALTHY, HAPPY LEARNING

NUTRITION

Many children stop eating breakfast when they start school. Don't let this happen to your child! Teachers tell us eating breakfast helps children learn better.

WHY NOT FIX A FAST FOOD BREAKFAST?

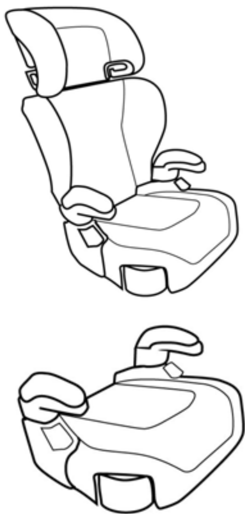
Children enjoy:

- Pieces of fruit or raw vegetables
- Hard cooked eggs
- Chunks of cheese
- Left over pizza, chicken, . . .
- Peanut butter and jelly sandwiches

REST AND SLEEP

A rested child enjoys and does better in school. Most children need at least eight (8) hours of sleep each night. Help your child get enough rest and sleep.

SAFETY



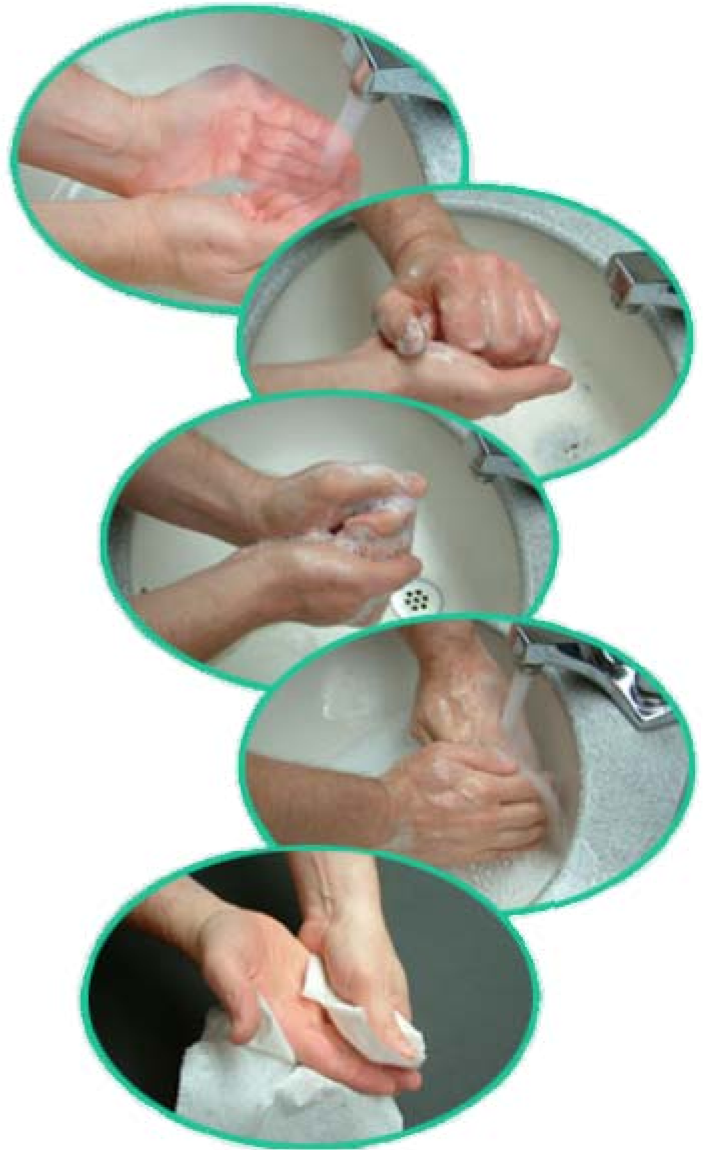
Accidents are the greatest single threat to your child's life. They are the leading cause of death among children from one to fourteen years of age.

Children should:

- Know their full name, address and phone number.
- Ride in a booster seat and seatbelt until 8 years of age, or until they reach 57 inches tall.
- Follow the safest route to walk to school.
- Follow the rules when crossing the street.
- Follow the crossing guard's instructions.
- Play safely in school and on the playground.
- Avoid talking to or going anywhere with strangers.
- Wear helmets and protective gear when riding bikes or roller blades.

WASH HANDS WELL

WET your hands with warm RUNNING WATER. Add SOAP to your hands.



RUB your hands

WASH ALL SURFACES for 20 seconds including:

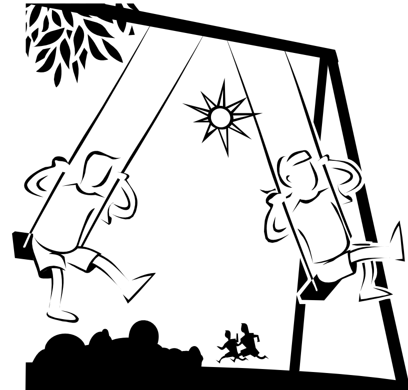
- **Backs of hands**
- **Wrists**
- **Between fingers**
- **Under fingernails**

RINSE well

DRY hands with a paper towel

Use the PAPER TOWEL to turn off the faucet and open the door.

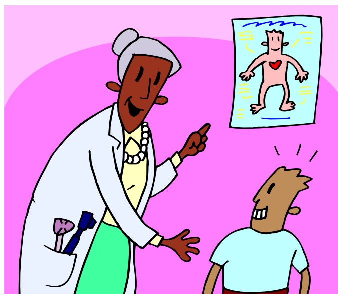
In case of injury or illness



- It is important for the school to have an **EMERGENCY TELEPHONE NUMBER** in case your child is injured or becomes ill.
- Please keep the telephone number current.

When you child is ill

- Report the absence on the first day.`
- Tell the school what signs of illness your child has.
- Keep your child home until he/she is fever free for 24 hours without the use of fever reducing medicines such as acetaminophen or ibuprofen.



Report the following signs of illness:

- Red or watery eyes
- Earache or discharge from ear
- "Runny" nose
- Cough or sneezing
- Muscle aches of the back, arms and/or legs
- Upset stomach or vomiting
- Diarrhea
- Fever or chills
- Rash or spots on the skin
- Red or sore throat

INFORMATION SCHOOL NEEDS TO REGISTER YOUR CHILD:

- ❑ IMMUNIZATION RECORD
- ❑ HEARING TEST RECORD
- ❑ VISION TEST RECORD

IF NOT RECORDED ON THE HEALTH APPRAISAL FORM

- ❑ BIRTH CERTIFICATE
- ❑ PARENT ID ie. DRIVER'S LICENSE OR STATE ID
- ❑ CUSTODY PAPERS (IF APPLICABLE)
- ❑ SCHOOL ENROLLMENT FORMS-**CONTACT SCHOOL**
- ❑ PROOF OF RESIDENCY-**CONTACT SCHOOL FOR REQUIREMENT**

HELPFUL TELEPHONE NUMBERS

SCHOOL NAME ________________________________

PHONE NUMBER________________________

ABSENCE NUMBER _____________________

HEALTH DEPARTMENT NUMBERS

IMMUNIZATION CLINICS

- MT CLEMENS.....................................(586) 469-5372
- ST CLAIR SHORES............................(586) 466-6800
- WARREN ....(586) 465-8537

HEARING AND VISION SCREENING............(586) 412-5945

DENTAL CLINIC ....(586) 465-9152

MI CHILD-HEALTHY KIDS INSURANCE ....(586) 469-5492

______________________________ ______________

______________________________ ______________

______________________________ ______________

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HEALTH APPRAISAL

Dear Parent or Guardian: The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. (**BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION**.)

PERSONAL

CHILD'S NAME (Last, First, Middle)			DATE OF BIRTH (mm/dd/yy) / /
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER ( )
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	WORK TELEPHONE NUMBER ( )

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?
☐	☐	☐	1 Allergies or Reactions (for example, food, medication or other)
☐	☐	☐	2 Hay Fever, Asthma, or Wheezing
☐	☐	☐	3 Exzema or Frequent Skin Rashes
☐	☐	☐	4 Convulsions/Seizures
☐	☐	☐	5 Heart Trouble
☐	☐	☐	6 Diabetes
☐	☐	☐	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements
☐	☐	☐	9 Shortness of Breath
☐	☐	☐	10 Speech Problems
☐	☐	☐	11 Menstrual Problems
☐	☐	☐	12 Dental Problems: Date of Last Exam / /
☐	☐	☐	Other (please describe): ____________
☐	☐		Does your child take any medication(s) regularly?

Reason for Medication

______________________ / /
Parent/Guardian Signature Date

Birth History:

Are there any current or past diagnosis(es) ☐ Yes ☐ No

If yes, please describe:

If yes, list medications:

Was the health history reviewed by a health professional?
☐ Yes ☐ No ***Examiner's Initials:*** ____________

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	VISION Date: / /	Visual Acuity			
			Muscle Imbalance			
			Other:			
☐	☐	HEARING Date: / /	Audiometer			
			Other:			
☐	☐	URINALYSIS Date: / /	Sugar			
			Albumin			
			Microscopic			
☐	☐	BLOOD LEAD LEVEL Date: / /	Level ______ ug/dl ⇨			

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
☐	☐	Other: ____________	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading: ____________			
☐	☐	TUBERCULIN Date: / /	Type: ____________ Neg.: ☐ Pos.: ☐ ______ mm			

NOTE: Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.

Examinations and/or Inspections

Essential Findings Deviating from Normal:

Exam Date: / /

SECTION III - IMMUNIZATIONS

Statements such as "UP TO DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (Hep B)	1	3
	2	
DTaP/DTP/DT/Td	1	4
	2	5
	3	6
Tdap	1	
Haemophilus Influenzae type b (HIB)	1	3
	2	4
Polio - IPV / OPV	1	3
	2	4
Pneumococcal Conjugate (PCV7/PCV13)	1	3
	2	4
Rotavirus (RV1/RV5)	1	3
	2	
Measles,Mumps, Rubella (MMR)	1	2
Varicella (Chickenpox)	1	2

History of Cickenpox Disease? ☐ Yes ☐ No If yes, date:

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (Hep A)	1	2
Influenza TIV/LAIV	1	3
	2	4
Meningococcal MCV4 / MPSV4	1	2
Human Papillomavirus (HVP4/HPV2)	1	2
	2	3
OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	1	
	2	
	3	

Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable

*NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your child's school or local health department.

Parent/Guardian refused immunizations: ☐

I certify that the immunization dates are true to the best of my knowledge

Health Professional's Signature ____ Title ____ Date ___/___/___

SECTION IV - RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

No	Yes	
☐	☐	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain:
☐	☐	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): ☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Other

Other Recommendations

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined ____________ (child's name)'s teeth. As a result of this examination, my recommendation for treatment is: ____________

Dentist's Signature ____ Date ___/___/___

PHYSICIAN'S SIGNATURE

Examiner's Signature ____ Date ___/___/___ *Examiner's Name (Print or Type)* ____ Degree or License ____

Number & Street ____ City ____ MI ZIP Code ____ ( ) Telephone ____

Information required for:

Early On - Hearing and Vision Status; Diagnosis; Health Status

Child Care Licensing - Physical Exam, Restrictions, Immunizations

Head Start/Early Head Start - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the schedule of well-child care required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia and regular intervals based on age.

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Developed in Cooperation with the Departments of Human Services, Education, Community Health, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.

Mark A. Hackel
County Executive

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